COMMONWEALTH OF MASSACHUSETTS
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DIVISION OF INSURANCE
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FILING GUIDANCE NOTICE 2025-D

TO: Commercial Health Insurers; Blue Cross Blue Shield of Massachusetts, Inc.; and Health Maintenance Organizations Offering or Renewing Insured Health Products in Massachusetts ("Carriers") Subject to M.G.L. c. 176O

FROM: Kevin P. Beagan, Deputy Commissioner, Health Care Access Bureau

DATE: March 4, 2025

RE: Managed Care Procedures to Review the Prior Authorization of a Transfer from an Inpatient Facility to Post-Acute Care Pursuant to Chapter 197 of the Acts of 2024

The Division of Insurance ("Division") distributes this Filing Guidance Notice 2025-D to inform insured health carriers ("Carriers") regarding filing requirements associated with new provisions in Section 24 of Chapter 197 of the Acts of 2024 ("Chapter 197"), which applies to all insured health plans issued or renewed in Massachusetts. The noted statute establishes managed care procedures for transfers to post-acute care from an inpatient hospital stay for all insured health benefit plans issued or renewed in Massachusetts.

Transfer from an Inpatient Facility to Post-Acute Care

As noted in Chapter 197, insured health benefit plans issued or renewed in Massachusetts are required to "approve or deny a request for prior authorization for admission to a post-acute care facility or transition to a post-acute care agency for any inpatient of an acute care hospital requiring covered post-acute care services by the next business day following receipt by the payer of all necessary information to establish medical necessity of the requested service; provided, however, that no new admission may occur until the applicable pre-admission screening and resident review required pursuant to 42 CFR 483 is complete." Post-acute care facility or agency is defined as "any (i) facility licensed under chapter 111 of the General Laws to provide inpatient post-acute care services, including, but not limited to skilled nursing facilities, long-term care hospitals, intermediate care facilities, or rehabilitation facilities; or (ii) a home health agency certified by the federal Centers for Medicare and Medicaid Services."

The law also states that, "[i]f the calendar day immediately following the date of submission of the completed request is not a payer's business day, and the payer cannot otherwise make a determination by the next calendar day, and the receiving post-acute care facility or agency is both open to new admissions and has indicated that said facility or agency will accept the enrollee, then prior authorization shall be waived; provided, that the payer shall provide coverage and may

begin its concurrent review of the admission on the next business day; provided further, that the payer shall not retrospectively deny coverage for services to an enrollee admitted to a post-acute care facility or transitioned to a post-acute care agency after a waiver of prior authorization pursuant to this section unless the claim was a result of fraud, waste or abuse."

It is further noted that "[a]n adverse determination of a prior authorization request pursuant to this section may be appealed by an enrollee or the enrollee's provider and such appeal, in the case of an enrollee of a commercial payer, shall be subject to the expedited grievance process pursuant to clause (iv) of subsection (b) of section 13 of chapter 176O of the General Laws….Nothing in this section shall be construed to require a payer to reimburse for services that are not a covered benefit."

The Division expects that a day lasts until midnight and that a business day lasts until the end of normal business hours. Carriers should base the timing of decisions accordingly[1].

Filing Requirements

As required under 211 CMR 52.05(7), Carriers are to submit material change materials - including the Carrier's Evidence of Coverage as described in 211 CMR 52.05(4)(i) - for the Division's review. The material change document should note that the statutory change identifies benefits that are to be part of insured health coverage offered or renewed in Massachusetts. Please forward all form filings to update the Evidence of Coverage on file, using SERFF (the System for Electronic Rate and Form Filing), with the SERFF Project Name: Chapter 197 of the Acts of 2024.

Carriers are also expected to review requests for the required services according to the medical necessity requirements identified in M.G.L. c. 176O, 211 CMR 52.00, and Chapter 197, including complying with required review timelines, notifying the covered person of all utilization review decisions, and informing individuals in an expedited manner about their rights to internal and external appeals when there has been an adverse determination of a request for services. In order to comply with 211 CMR 52.05(7) for utilization management systems, please forward a signed certification that the Carrier will comply with utilization management procedures for transfers to post-acute care from an inpatient hospital stay in accordance with M.G.L. c. 176O and 211 CMR 52.00.

If you have any questions about Filing Guidance Notice 2025-D, please contact Niels Puetthoff at Niels.Puetthoff@mass.gov.

[1] If a request for transfer to a post-acute care facility and all necessary information to establish medical necessity of the requested service is received before midnight on a particular day, the Carrier should make a determination by no later than the end of the next normal business day. If a request is received before midnight on Friday, the Carrier should make a determination no later than the next normal business day, which may be the following Monday or Tuesday if the Carrier does not conduct normal business over the weekend or on holidays.